maternity departments, where general practitioners can treat their own patients. The private hospitals are independent, but the State controls several technical aspects of their work, and most of them have entered into agreements with the social security system whereby patients are reimbursed according to tariffs fixed annually.

In France the right to health care, whenever it is received, is guaranteed and financed by different systems covering different risks—for example, illness, maternity, disability, and accidents at work. Patients pay for their medical care and are then reimbursed in part or in whole under one of the various insurance schemes (see table.) Medical Care Insurance also pays sickness benefits to employees; medical care for accidents at work is free and there is a disability insurance scheme under which patients receive a pension.

Reimbursements by French Society System

Category	Refund (%)
Medical fees	
Hospital expenses	
(over 30 days stay 100%)	80
Short drugs	70
Very expensive drugs (for example cortisone, antibiotics)	90
Dental care, assessment and treatment	70
Particularly expensive treatment	100
Surgery, other than minor operations	100
Long-term illness	100

Social Security

Social security in France is a collective and compulsory system of protection against certain risks. It is not a government agency but an autonomous body, whose boards include an equal number of representatives of the employers and of the trade unions. Both employers and workers contribute to the scheme—thus for a monthly salary of about £200, the respective percentages contributed are 10·25 and 2·5 of the salary.

What are the benefits of membership of the E.E.C. to the individual patient? Since October 1972 the reciprocal social security arrangements have meant that an Englishman or a German living permanently in France, or on holiday, has had the same advantages as a Frenchman.

He has only to produce the certificate proving that he is covered by the insurance system in his home country. A clearing system has been set up between the various social agencies to settle financial problems, and these arrangements already cover two and a half million people. A Frenchman will also be able to receive hospital care in another member's state and to have his expenses paid provided he is covered by the French social security system. This benefit is not yet available to foreigners in France.

There is still a long way to go before total "harmonization" is achieved and I believe that the patient will not benefit fully until agreement has been reached on the question of the free circulation of doctors within the community. This proposal has received much opposition but I have travelled through most of the countries of the community and I do not think that the health of the various populations differs notably from one to the other. Instead of the endless meetings where the comparative value of curricula and specialist training programmes are discussed, I would suggest a European survey, by an international panel of epidemiologists on, for example, the way in which five or six medical or surgical emergencies, and five or six chronic diseases are treated in the community. We should be surprised by the similarity of the methods employed and the results obtained.

I believe that the European Community has no real meaning unless its human and social aspects are enhanced as well as the economic ones. Medicine can and should play an important part in achieving this.

Créteil, France
J. L. PORTOS, M.D., Professor of Medicine

The Netherlands

C. L. C. VAN NIEUWENHUIZEN

Within the E.E.C. all employees in other member states staying for less than 12 months in the host country continue to be insured by their home country, but receive medical attention under the prevailing insurance system of the host country. If the employee stays in the Netherlands longer than 12 months he will be admitted to our insurance system and will have to pay his share of the premium.

In the Netherlands, as in the U.K., the patient visits the specialist via the general practitioner (though in exceptional cases a private patient may apply to the specialist directly). Medical specialists are registered by the Royal Netherlands Medical Association, whose Central College produces a list of recognized specialties, and lays down rules for training, which is recognized both by the social security system and by the hospitals. Since 1930 the Royal Medical Association has been responsible for registering specialists, through a special committee. The Central College, however, does more; among other things it has examined the distribution of specialists in the Netherlands, of their ages and when they will need to be replaced.

If I have learned anything during the fifteen years I have been studying the guide lines for the free establishment of the liberal professions, then it is that we should not prejudge the value of the systems in other countries. Thus I was no little surprised that the attitude of British doctors towards the E.E.C. was just the same as I had observed among the doctors' representatives in the Six some 10 or 12 years ago; they were afraid of a mass invasion of doctors from abroad and that the standard of medical treatment would be lowered in their country. For this reason demographic examinations are of vital importance. The National Hospital Institute is an independent scientific body of the Dutch hospitals and may be compared with your King's Fund. Their report on the distribution of hospital specialists, which was commissioned by the Central College, contains a wealth of information, and if we had a similar account for every country we could make some forecasts about the movement of specialists within Europe. Similar statistics for health care as a whole might also be just as important. Nevertheless, such problems cannot be solved by doctors alone, but need a team including statisticians, epidemiologists, and planning specialists.

Utrecht, The Netherlands
C. L. C. VAN NIEUWENHUIZEN, M.D., Cardiologist

Denmark

AAGE PEDERSEN

Under certain circumstances many of the benefits available to Danish patients are also available to those of other member states in the Common Market; moreover, I am convinced that some of the Danish "arrangements" may have some influence on the directives to be issued by the council in Brussels.

For years Denmark as well as the other Scandinavian countries, the United Kingdom, France, West Germany, and Switzerland, have been signatories to agreements on social security. For example, the agreement between the United Kingdom and Denmark applies to such things as health insurance, national pensions, disablement annuities, unemployment insurance, widows' pensions, and child welfare. Despite these agreements there were so many differences remaining between countries that the Council of Ministers had to issue a decree about employees and their families who had moved from one country to another within the Common Market. This defined an "employee" as "any person who is insured in pursuance of the compulsory insurance arrangement or in pursuance of a voluntary permanent insurance against one or several risks, in conformity with the various branches of insurance incorporated in a social security arrangement."

By an Act of Parliament, which came into force in Denmark on 1 April 1973, all citizens have to belong to the public health insurance scheme. Under the scheme the population falls into two groups. People in the first group, with an annual income of less than £3,000, are entitled to free medical attention from a general practitioner to whom they are allocated and to free medical attention from specialists in the health insurance system, provided that they are referred by their general practitioner. The fees are defrayed by the health insurance authorities in the form of "capitation fees." The second group, Danes who earn over £3,000 a year, have the option of choosing their general practitioner, to whom they pay fees; they are reimbursed in accordance with a specific price schedule on application to the health insurance authorities.

Hospital Treatment

Members of both groups are entitled to free hospital treatment and maternity care and, under some conditions, to such things as dental care, travelling expenses, bandages, glasses, *x*-ray examinations, laboratory tests, and convalescence. A travellers' health insurance is also available, covering medical care and, if required, repatriation from countries in Europe. This is valid for two months. Recently subsidies on the cost of prescriptions have been granted, irrespective of the patient's economic status. All medical preparations have been classified into three sections, based on medical evaluation of their therapeutic value; due regard is paid to the nature of the disease to be treated and to the patients' ability to pay. Thus specific and valuable drugs such as levodopa or antibiotics are subsidized by 75% of their cost, less valuable agents such as tranquillizers by 50%.

All citizens are entitled to free prophylactic examinations, and to inoculation and vaccination against varicella, diphtheria, tetanus, polio, and pertussis. These costs are defrayed by the local health authorities and the local social services system and are reimbursed by State subsidies.

Temporary residents from the United Kingdom and other Scandinavian countries are entitled to all of the services under the health insurance system on production of the appropriate identification papers certifying that they are members of their own national health insurance scheme. Persons from other countries in the Common Market have to present further documentary evidence before they can take advantage of Danish health services.

Under Bills passed this year free abortion, sterilization, and gonadectomy are available to Danish nationals and, after fulfilment of E.E.C. regulations, to nationals of other member states who have taken up permanent residence in Denmark. Abortion is not undertaken unless the woman personally wants to have her pregnancy terminated before the 12th week of pregnancy, and provided that a gynaecologist can be persuaded to perform the operation. It goes without saying that women who come to Denmark for only a brief stay are not entitled to a free abortion.

Other Benefits

Among the numerous other benefits available to Danish nationals are the old age pension and the disablement annuity. From 1 January 1973 it has been a requirement that nationals of other member states have to stay and work in Denmark for at least a year before they are entitled to apply for these insurances or to have had permanent residence in Denmark for five consecutive years. A "daily benefit scheme" is also in operation; it starts on the first day of disablement, and the patient receives 90% of his average daily income, the only requirement being that he must produce a certificate signed by his employer, testifying that he has been working not less than 40 hours over the month before the illness or accident. Hence the scheme does not apply to tourists.

Hellerup, Denmark
AAGE PEDERSEN, M.D., General Practitioner

Great Britain

JOHN L. KILGOUR

I would first like to note the significant step forward which I believe was made in Brussels last month (see *B.M.J. Supplement*, 10 November, p. 39) by the establishment of some broadly consensus views at the public hearing convened by Commissioner Dahrendorf. Probably these agreements will facilitate the acceptability of some propositions with which the U.K. government has been associated. If I am right we are all brought measurably nearer the achievement of one of the aims of the Treaty of Rome, enshrined particularly in Article 57—the freedom of circulation and the establishment of one at least of the liberal professions. This is not to say that I expect immediate agreement, but that progress over cardinal points of interest should now be possible with eventual agreement now a probability rather than a possibility.

My subject today is to outline the position of the E.E.C. citizen in the United Kingdom as a patient. The U.K. follows a good samaritan policy which extends this right of access to all its residents, including its temporary residents—that is, those who may be visiting its shores for whatever reasons (except specifically to obtain medical care). This includes, of course, our friends from our partner countries in the European Community. There are no formalities beyond the briefest essentials. The N.H.S. has been careful to preserve the freedom of choice both for the patient in selecting his doctor of primary contact and for the doctor accepting his patient, such freedom being only qualified by the unavoidable constraints imposed by geographical accessibility.

In the United Kingdom we have noted with interest the developments in the delivery of health care in the countries of the six founder members of the Community, and whether these services have been funded centrally or are based on the insurance principle. Despite differences due to the varying historical experience in each country, the changes have all seemed to be on a converging path towards the goal of universal access to necessary care for all, without administrative or financial obstacle at the time of need. This is, of course, because the social and political pressures in each country tend the same way, and this co-ordination and achievement of aim possibly by separate methods would surely have pleased the drafters of the Treaty of Rome. It is in the spirit of the directives—agreeing an aim and leaving the method of attainment to each country rather than by regulatory prescription—that I believe we shall come closer together in the field of health and what we offer to the patient in Europe.

Department of Health and Social Security, London
JOHN L. KILGOUR, M.B., CH.B., Principal Medical Officer

Maternity Services

Chairman's Address: Great Britain

JOSEPHINE BARNES

The number of births annually in Great Britain is now about 700,000, having fallen progressively in recent years. Perhaps the most important change has been the tendency for women in Britain to have their babies in hospital rather than at home. In 1927 15% of live births in England and Wales took place in hospital. By 1970 the percentage of hospital deliveries had risen to over 80%. This has been achieved by the provision of more hospital beds, by the practice of sending women home early after delivery, and, to a large degree, by the mothers themselves, who have come to prefer hospital delivery.